New Jersey Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled (PAAD),
Lifeline and Special Benefit Programs
Senior Gold Prescription Discount Program (Senior Gold)
P.O. Box 715
Trenton, NJ 08625-0715

UNIVERSAL APPLICATION FOR PAAD, SENIOR GOLD AND OTHER SPECIAL BENEFIT PROGRAMS

By filling out the attached application, you may be eligible for benefits provided by the Pharmaceutical Assistance to the Aged and Disabled (PAAD) or the Senior Gold Prescription Discount programs. **This application is ONLY for people who are applying for PAAD or Senior Gold benefits for the first time.**

PAAD and Senior Gold are state-funded prescription programs that help eligible New Jersey residents with the cost of prescribed medication (including insulin, insulin needles, and needles for injectable medicines used for the treatment of multiple sclerosis).

While you are applying for assistance with your prescription costs by filling out this application, you may be eligible for several other valuable benefits *if you are eligible for PAAD*. For example, if eligible for PAAD, you may be eligible for benefits through the Lifeline utility assistance and Hearing Aid Assistance to the Aged and Disabled programs.

Once you are on the PAAD program, you may qualify for a property tax freeze, reduced motor vehicle fees, and Communications Lifeline.

Further, by filling out this application, you will be screened for benefits provided by the Universal Service Fund (USF) and the Low-Income Home Energy Assistance Program (LIHEAP) – two more programs that help pay for utility costs. In addition, you will be screened for "Extra Help with Medicare Prescription Drug Plan Costs" – a program that helps pay Medicare Part D costs; the Specified Low-Income Medicare Beneficiary (SLMB) or SLMB Qualified Individual programs – two programs that pay Medicare Part B premiums; and the New Jersey Supplemental Nutrition Assistance Program (NJ SNAP) – also known as Food Stamps, this program provides supplemental nutrition assistance to help people who meet certain income criteria buy groceries.

If it appears that you may be eligible for USF, LIHEAP, the "Extra Help," SLMB/SLMB QI-1 and/or NJ SNAP, PAAD will apply for these benefits on your behalf.

Turn this page over for a comparison of PAAD and Senior Gold.

For More Information,
Visit www.njpaad.gov or www.njsrgold.gov
Or, Call 1-800-792-9745

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This form will be scanned for computerized data capture. Please follow these instructions to ensure that your application is processed quickly and accurately.

- **Use blue or black ink. Do not use red ink or pencil.**
- **Print clearly in uppercase block letters (see examples below).**
- **Print only one number or letter in each box.**
- **Stay inside boxes.**
- **Correct errors with white correction fluid.**

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z
1	2	3	4	5	6	7	8	9	0			

If you have questions or need help filling out this form, call toll free 1-800-792-9745

This form must be completed and returned to:

PAAD/Senior Gold
Revenue Processing Center
PO Box 637
Trenton, NJ 08646-0637

DO NOT SEND ORIGINAL SUPPORTING DOCUMENTS. SEND COPIES. ORIGINALS WILL NOT BE RETURNED.

Please see reverse for list of necessary documents.

New Jersey Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled (PAAD), Lifeline and Special Benefit Programs/Senior Gold Prescription Discount Program (Senior Gold),
PO Box 637, Trenton, NJ 08646-0637 Toll Free Hotline 1-800-792-9745

I am applying for: **Prescription Assistance** ☐ **Lifeline Utility Benefit** ☐ **Both** ☐

PLEASE PRINT YOUR NAME ON THE TOP OF EACH PAGE.

1. Enter your name, date of birth and sex. List your Social Security number. Use CAPITAL LETTERS. Print only one letter or number in each box. List date of birth verified by Social Security.

Last Name | **Suffix (Jr., Sr., etc.)**

First Name | **Middle Initial** | **Sex Male/Female**

Social Security Number ___ - ___ - ____

Date of Birth Month / Day / Year

2. Even if your spouse is not applying, we need all of the questions answered and signatures for both of you, if married and living together.

Spouse's Last Name | **Suffix (Jr., Sr., etc.)**

First Name | **Middle Initial** | **Sex Male/Female**

Spouse's Social Security Number ___ - ___ - ____

Date of Birth Month / Day / Year

3. Please identify your current marital status. Please [X] only one box.

Married ☐ Separated* ☐ Single ☐

Widowed ☐ Divorced ☐

3b. Has your marital status changed in the last year? **YES** ☐ **NO** ☐ List the date of change ___/___/____ Month / Day / Year

*If you are separated from your spouse, call the toll free number above to request form 'Affidavit of Separation' which MUST accompany this application.

3c. Are you or your spouse, if married, residing in a long-term care facility (nursing home)? If YES, submit a letter from the facility indicating the date admitted.

YOU: **YES** ☐ **NO** ☐

SPOUSE: **YES** ☐ **NO** ☐

Name: _____

Income

7. If you (or your spouse, if married and living together) receive income from any of the sources listed below, please enter the **total current YEARLY income** in the appropriate boxes. **DO NOT LIST CENTS**. Do **not** list Social Security, wages and self-employment, public assistance, medical reimbursements or foster care payments here. If you (or your spouse) do not receive income from any of the sources listed below, place an X in the NONE box.

• Railroad Retirement	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Veterans	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Other pensions	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Annuities	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• Other income not listed above, including net rental income, workers compensation, alimony (Specify) Net Rental ☐ Alimony ☐ Worker's Comp ☐ Other ☐	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐

8. Have any amounts included above decreased in the last two years? **YES** ☐ **NO** ☐

9. Have you (or your spouse) worked in the last 2 years?

YOU:	**YES** ☐	**NO** ☐
SPOUSE (if living together):	**YES** ☐	**NO** ☐

10. If you or your spouse answered **YES**, list current **YEARLY** amounts below:

• What do you expect to earn in wages before taxes **THIS YEAR**?	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐
• If self-employed, what do you expect your net earnings or loss to be **THIS YEAR**?	**YOU:** **SPOUSE** (if living together):	**NONE** ☐ **NONE** ☐	$ ☐☐,☐☐☐ $ ☐☐,☐☐☐

• If you (or your spouse) expect a net loss, put an X here: **YOU:** ☐ **SPOUSE:** ☐

11. Have any amounts included above decreased in the last two years? **YES** ☐ **NO** ☐

Name: _____

Low Income Subsidy and SLMB ASSET

IMPORTANT NOTICE:
The asset information WILL NOT be used as a requirement by the State of New Jersey for the PAAD, Lifeline, HAAAD or Senior Gold Programs. The asset information is required to determine eligibility for extra Medicare benefits and will only be used for that purpose.

15. If you are single, a widow(er) or your spouse does not live with you, are your **savings, investments** and **real estate (other than your home)** worth more than $13,070? If you are married and living together, are they worth more than $26,120? Include the things you own by yourself, with your spouse or with someone else. **DO NOT include the value of your home, vehicles, burial plots or personal possessions in this amount.**

YES ☐ **NO/ NOT SURE** ☐

If you put an X in the **YES** box, you are not eligible for the extra help, skip questions 16 through 21 and continue at question 22.

16. Enter the money amounts of bank accounts, investments or cash that either you, your spouse (if married and living together) or both of you own in the boxes below. Include items that either of you own with another person. If you or your spouse (if married and living together) do not own an item listed, either separately, jointly or with another person, place an X in the NONE box.

• Bank accounts (checking, savings, and certificates of deposit)	**NONE** ☐	$ ☐☐,☐☐☐
• Stocks, bonds, savings bonds, mutual funds, Individual Retirement Accounts or other similar investments	**NONE** ☐	$ ☐☐,☐☐☐
• Any other cash at home or anywhere else	**NONE** ☐	$ ☐☐,☐☐☐

17.

Do you (or your spouse, if living together) own a vehicle? **YES** ☐ **NO** ☐

Is the vehicle used for work or for transportation to medical care? **YES** ☐ **NO** ☐

List all vehicles (if you need more space attach an additional sheet of paper)

Owner's Name	Year/Make	Amount Owed	Current Value
			$ ☐☐,☐☐☐
			$ ☐☐,☐☐☐

Name: _____

24. Lifeline Utility Credit/ Tenants Lifeline Assistance Program

Are you applying for Lifeline utility or tenants benefits? **YES** ☐ **NO** ☐
If **YES**, complete only section **A** or **B**, not both.

Check **NO** if you are **NOT an Electric or Natural Gas customer** AND **your utilities are NOT included in your rent payment.** Supplemental Security Income (SSI) beneficiaries should not apply, the Lifeline utility benefit is already included in monthly SSI checks. Only one ANNUAL $225 Lifeline benefit will be issued per household. When two or more persons share a household, Lifeline will only accept one application from that household.

A. LIFELINE CREDIT PROGRAM:

Enter your utility account number(s) exactly as listed on the bill(s). Submit **a copy of your most recent bill/statement(s)**. Bill(s) must show your name, address and account number. List the name as shown on the bill and identify that person's relationship to the applicant.

Utility Codes

01 Public Service Electric & Gas
02 Elizabethtown Gas
03 NJ Natural Gas
04 South Jersey Gas
05 Atlantic City Electric
06 Jersey Central Power & Light
07 Orange/Rockland Electric
08 Sussex Rural Electric
09 Butler Electric
10 Lavallette Electric Dept
11 Madison Water and Light Dept
12 Milltown Electric Dept
13 Park Ridge Electric Dept
14 Pemberton Electric Dept
15 Seaside Heights Electric Dept
16 South River Bd of Public Works
17 Vineland Municipal Utilities

For office use only:
No change_____ Cat/C _____

S/C _____ C/C_____

Electric Company Utility Code ☐☐ Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name on Electric Bill

First ☐☐☐☐☐☐☐☐ Last ☐☐☐☐☐☐☐☐☐☐

Relation to Applicant

Self ☐ Spouse ☐ Family member ☐ Landlord ☐ Other ☐

Gas Company Utility Code ☐☐ Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Name on Gas Bill

First ☐☐☐☐☐☐☐☐ Last ☐☐☐☐☐☐☐☐☐☐

Relation to Applicant

Self ☐ Spouse ☐ Family member ☐ Landlord ☐ Other ☐

B. TENANTS LIFELINE ASSISTANCE PROGRAM:

To be eligible for Tenants Lifeline you must be a tenant and have the cost of your electric and gas included in your rent. Only list your landlord's name and address if your electric and gas are included in your rent.

List the monthly amount of rent that you pay: $ ☐, ☐☐☐

Landlord's Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Landlord's Address ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City, State, Zip Code ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐ ☐☐☐☐☐

Put an [X] in the box that most accurately describes your principal place of residence. **Please complete this section.**

Own House ☐	Condominium ☐	Apartment ☐	Boarding Home ☐
Rent House ☐	Mobile Home Site ☐	Assisted Living Facility ☐	Nursing Home ☐
Other ☐	Explain:_____		

Name: _____

28. Signatures

I understand that the Social Security Administration (SSA) will check my statements and compare its records with records from Federal, State, and local government agencies, including the Internal Revenue Service (IRS), to make sure the determination is correct. By submitting this application, I am authorizing the SSA to obtain and disclose information related to my income, resources, and assets, foreign and domestic, consistent with applicable privacy laws. This information may include, but is not limited to, information about my wages, account balances, investments, benefits, and pensions. I declare under penalty of perjury that I have examined all the information on this form and it is true and correct to the best of my knowledge.

I certify that to the best of my knowledge I meet the Programs' eligibility requirements and will notify the Programs immediately if my income rises above the legal limit, or if I move from New Jersey, or if I become Medicaid eligible. If I am determined eligible based on my disability, I will return my eligibility card if I stop receiving Social Security Disability Benefits. I authorize the release of information necessary to determine my eligibility from the records in possession of the SSA, IRS, New Jersey Division of Taxation, New Jersey Division of Medical Assistance and Health Services, employers, banks, utility companies and others as the need arises. I authorize my physician(s) to release information concerning prescriptions that have been paid on my behalf by the Program. I hereby assign the State of New Jersey as my authorized representative, any right to drug benefits to which I may be entitled under any other plan of assistance or insurance, from any other liable third party or drug benefits under any other plan of governmental assistance. I certify that I am the utility customer of record or tenant at the address indicated as my principal place of residence. I understand that the State of New Jersey is entitled to repayment of incorrectly provided payments. It is further understood that I may be held liable for repayment of any benefits or payments which are determined to have been incorrectly provided. I am authorizing PAAD to disclose to other state agencies the financial information listed above, utility information and other individually identifiable information from my file, such as my name, date of birth, and social security number to start the application process for Medicare Savings Programs, USF/LIHEAP and the Supplemental Nutrition Assistance Program (SNAP).

Please complete Section A. If you cannot sign, a representative may sign for you. If someone assisted you, complete Section B as well.

SECTION A

Your Signature:	Phone Number: (___) ___-____
Your Spouse's Signature:	Date: __ / __ / __

If you would prefer that we contact someone else if we have additional questions, please provide the person's name and a daytime phone number.

First Name:	Last Name:	Phone Number:
		(___) ___-____

SECTION B

If you are assisting someone else in completing this application, place an X in the box that describes who you are and provide your daytime phone number and address.

Family Member ☐	Attorney ☐	Other Advocate ☐	Social Worker ☐
Friend ☐	Agency ☐	Other Specify:_____	☐

First Name:		Last Name:	
Street Address:		Apt #:	
City:	State:	Zip Code:	
Preparer signature:		Phone Number:	(___) ___-____

Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled

MEDICARE PART D PDP ENROLLMENT ASSISTANCE FORM

Applicant Name:	
Telephone Number:	Social Security Number:

Please choose one:

1) ☐ **If I am determined eligible for PAAD, please ENROLL me in a Medicare Part D plan for which PAAD will pay the premiums.** I have listed my medications below.

2) ☐ **If I am determined eligible for PAAD, please DO NOT switch my current Medicare Part D Plan.** I will be responsible for the premiums.

3) ☐ **I am enrolled in a Medicare Advantage plan with prescription coverage.**

4) ☐ **I have prescription coverage through a retiree or union health plan, which has notified me NOT to enroll in a Medicare prescription drug plan.** I am enclosing a copy of the notification.

☐ I CURRENTLY DO NOT TAKE ANY PRESCRIPTION DRUGS.

List the name of the pharmacy you use:

	Drug Name	Strength	Quantity
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

If you need to provide additional information, please attach a piece of paper with your name, Social Security number, and additional drug names, strength, and quantity. Thank you.